LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 10-05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

PART A EMPLOYER/PLAN SPONSOR

Employer/ Plan Sponsor	Control #	Account #/Location
North Dakota Public Employees Retirement System	**44374**	**1**

Date of Hire	Effective Date of Coverage	Employment Status
		☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This Change is due to: (Check all that apply) — Effective Date

☐ New Hire ☐ Annual Enrollment (Must complete an EOI Form) ☐ Decrease Coverage ☐ Change of Beneficiary

☐ Birth/Adoption (Date of Change_____/_____/_____) ☐ Marital Status Change (Date of Change _____/_____/_____)

PART B EMPLOYEE INFORMATION

Employee Name (Last, First, Mi)	Social Security Number	Employee I.D.#

Date of Birth	Marital Status	Gender	Work Telephone	Home Telephone
_____/_____/_____	☐ Single ☐ Married	☐ Female ☐ Male		

Employee Address	City	State	Zip Code

Department Name	Department Number

PART C EMPLOYEE COVERAGE

Basic Life

☒ Employee Only—Employer Provides $1,300 of Basic Life Coverage at no expense to you

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of $200,000 without providing evidence of insurability. After first eligibility, an Evidence of Insurability form (EOI) must be completed.

☐ I am applying for supplemental life coverage of: $_____. (Increments of $5,000) ☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: When you are initially eligible for dependent coverage, you can elect it without providing evidence of insurability. After initial eligibility, an Evidence of Insurability form (EOI) must be completed for approval by The Prudential Insurance Company of America.

☐ $5,000 for eligible spouse and $5,000 for each eligible dependent child. OR ☐ $2,000 for eligible spouse and $2,000 for each eligible dependent child.

☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse/ Life Election: Only available if you elected dependent coverage of $2,000 or $5,000 in Part D. When you are initially eligible for dependent spouse/ coverage, you can elect up to $50,000 in coverage without providing evidence of insurability. Total spouse/ coverage up to $100,000 is available if your spouse/ completes an Evidence of Insurability form for approval by The Prudential Insurance Company of America. Supplemental spouse/ coverage is limited to 50% of the employee's coverage amount.

☐ Amount of coverage $_____ (Increments of $5,000) Name _____ Date of Birth_____/_____/_____

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION (Designate your beneficiary(ies) below

Name of Primary Beneficiary (Last, First, Mi)	Relationship	Date of Birth	% Share (MUST =100%)	Address
Name of Contingent Beneficiary (Last, First, Mi)			% Share (MUST =100%)	Address

PART G AUTHORIZATION READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by The Prudential Insurance Company of America, provided I am actively at work.
- I understand that evidence or insurability may be required for coverage to become effective.

_____ Employee's Signature

_____ Date of Signature

PLEASE SIGN THIS FORM BEFORE SUBMITTING IT TO YOUR PAYROLL OFFICE

48467

Underwritten by The Prudential Insurance Company of America

GL.2005.201 Ed. 5/2005

Part A Employer/Plan Sponsor

Must be completed by an authorized agent.

Part B Employee Information

Employee must complete in its entirety.

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE

Part F Beneficiary Information

Use full legal name. (Example: “Anna May Smith,” not Mrs. John Smith”)

ESTATE DESIGNATION

If an estate is named, specify whose estate such as: “Estate of the Insured.” Full name and address of the executor must be included.

TRUSTEE DESIGNATION

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.

2. “The _____Trust Company, trustee under written trust agreement date (month, date, year) _____, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability.” Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

You must sign and date this section for this form to be valid.